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ABSTRACT

The author discusses the problematic term "community psychology" in relation to the many experiences he has had, personally, in the profession. When community psychologists concern themselves with social issues, they quite often adopt the "oversocialized conception of man," which allows for no change and rests firmly on the status quo. Another "trap" in which the psychologist finds himself concerns the possibility of embracing a sociology that actually denies the idiosyncratic psychological depths of the people he is attempting to help. One gives up being a psychologist in favor of becoming a reactionary sociologist. The author now finds himself attempting to organize an interdisciplinary program which has as its overlapping goals the study of psychosocial issues in health services and the implementation of psychosocial knowledge in all aspects of health care delivery systems. Community psychology can become an alternative within the psychological arena if other professionals will find ways of understanding and eliminating iatrogenesis (creation of additional problems in process of solving existing ones) in the medical and community mental health settings. (Author/PC)

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COMMUNITY PSYCHOLOGY: WHAT IT ISN'T

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COMMUNITY PSYCHOLOGY: WHAT IT ISN'T

"Community psychology" has always been a problematic term for me. I have never known whether it is meant to designate another specialized area within professional psychology or a complete redefinition of what psychology as a whole should be. I am not even sure whether I am a "community psychologist." The experiences in which I have thought of myself as a community psychologist seem quite different from one another--worlds apart, one could say. And the things I have done in those situations may not be at all in keeping with whatever professional norms are emerging as community psychological. Nevertheless, I think I have managed to learn some things about what community psychology is not. And from these negative discoveries perhaps a few implications can be drawn toward a more positive definition of a field of theory and practice.

I entered my first "world" of professional community experience while I was a community psychologist-in-training, and stayed there for almost two years. Fresh out of graduate school, I elected, quite starry-eyed, to do my "field experience" in an indigenously run, government supported, mental health "outpost" in the Black ghetto of Chicago's westside. Both simultaneously and at different times I served as a general program consultant, resource person, liaison agent, paraprofessional trainer and crisis interventionist. I was, in short, a marginal man. Of course, none of these community psychology-type functions had much meaning for the people I was working with.

I wonder if it was unusual four or five years ago to find university-

educated but naive idealist types imagining themselves to be Machiavellis in the mental health system. Well, at times I certainly did. It was often easier for me to approach the people I worked with in the abstract--as groups and organizations, conservative and liberal "elements," leaders and followers, agencies and consumers. But then isn't the marginal man in the best position to use such abstractions with objectivity? Perhaps, but suppose the marginal man is only marginal because he cannot get in ...? I wonder how many community psychologists there have been who have rationalized their fundamentally alienated positions into visions of Machiavellian power.

Well, one of the things that I learned from my experience in the ghetto is that community psychology is not sociology or political science.

I wonder about the sociologies of community psychologists. I have always found it easy to draw organizational charts--boxes, lines and arrows. There is certainly a sense of order to be found in these blackboard entities; but can it be found anyplace else? Social facts can be so disorderly. But perhaps even more troublesome than my flight from the ambiguities of empirical reality is the body of theory waiting to guide me back to that reality. The sociology often embraced by community psychologists represents some of the more conservative ideas in that field.

In 1961 Dennis Wrong (1961) wrote an essay called "The Oversocialized Conception of Man." In it he suggested that two closely related models of human nature guided much sociological theory and research. One model pictures each person as a summary of internalized social norms. A closely related model views people as motivated solely by the desire to achieve acceptance or status from others. The problem with these views of man is that they ignore the fact that people have bodies, that they have emotions,

and in general that they have experiences which may be less integrated but are just as real as the verbal logic of social role-playing. They deny any creative dialectic between the idiosyncratic desires and needs of individuals and the social structures that bind them together. By postulating that individuals are merely nodal points in a normative grid or that behavior is both other-directed and other-determined, these models overlook the very sources of change and novelty in society. The over-socialized view of man allows for no change and sits firmly on the status quo.

Yet, these are the models which community psychologists seem so often to adopt, both implicitly and explicitly, when they concern themselves with social issues.

Now in many places it is still pretty radical for a psychologist even to consider sociological variables. And community psychologists have rightfully concerned themselves with the structural forces of hospital wards, neighborhoods, family networks and mental health delivery systems. But when these community psychologists turn to a sociological interpretation of man as a completely socialized machine, they embrace a conservatism much more dangerous than that of the poor individual therapist who just wants to "do his thing." Hence, when a community psychologist is looking for a way to be a community psychologist, there is a trap awaiting him if he decides that community psychology is really practical sociology. The trap is the possibility of embracing a sociology that actually denies the idiosyncratic psychological depths of the people he is attempting to help. One gives up being a psychologist in favor of becoming a reactionary sociologist.

There have been, of course, many critiques within sociology of the

oversocialized conception of man. One recent example is Alvin Gouldner's (1970) book The Coming Crisis of Western Sociology. But it is perhaps most sensible for the aspiring community psychologist to look first at just what are the connections between social structures and specifically psychological variables. We cannot simply become sociologists; rather we must engage as scientists in discovering how the integrity of psychological life is maintained, enhanced or debased by supra-individual forces.

A useful working assumption for me derives from a concept developed in another context by the philosopher, Helmuth Plessner (1970; Grene, 1968). He speaks about the fundamental "eccentricity" of man's relationship to his body. While rejecting the metaphysics of a mind-body dualism, Plessner points out that the reflexivity of conscious experience yields a situation in which man not only is a body but has a body. Even while my body expresses itself in my feelings, I may feel "out of touch" with my body. Given this eccentric relationship, self-descriptions, for example, may be both the best possible descriptions at the time they are given and also inaccurate. This is a very useful perspective for psychology and Gendlin (1973) has approached the therapeutic process in terms of the articulation of this eccentric relationship.

But it is also a useful concept for community psychology if we view as "eccentric" the relationship between individual experience and the sociological situation in which that individual finds himself. It is an eccentric relationship because while one's experience is (as Dennis Wrong and others have pointed out) never isomorphic with the situation, it is also always embedded in the situation. Proceeding from this assumption, the community psychologist's job becomes neither the manipulation of social structures nor the "adjustment" of individuals but the discovery and facilitation of the eccentric relationship between individual experience and its social situation.

In recent years I have entered another position in which I have tried to act as a community psychologist. This one is perhaps a little less familiar than the first, where I might have been described, by many liberals, as being "where the action is"--or was. I have been attempting to organize an interdisciplinary program which has as its overlapping goals the study of psychosocial issues in health services and the implementation of psychosocial knowledge in all aspects of health care delivery systems. Some concerns of this program are: the social psychology of emergency rooms, the psychology of convalescence, the phenomenology of facial and dental pain, the psychology of stress, the ethics of psychopharmacology, the attitudes of health professionals to patients, patients to professionals and professionals to one another.

This may seem a long leap from the mental health problems of the ghetto. Actually, it is literally a couple blocks from the ghetto neighborhood where I once worked to the large university medical center where I am now located. (There are similar proximities in many cities.) But am I being as much of a community psychologist as I was when I did all those marginal things in a grass-roots outpost? I think I am; but I can best say how by telling you about another thing that I learned community psychology is not.

Community psychology is <u>not</u> a new kind of medicine. By this I mean to say that community psychologists, whoever they are, do not have some sort of gift, some psychological balm or special therapeutic herb, which once bestowed, endows the receiver with a better life, a healthier attitude or a greater "sensitivity." With a cursory glance at the literature of community psychology , you would think that community psychologists know this. There is, after all, a long-standing argument about what is called the "medical model" in clinical psychology. Most often this model is rejected. But I wonder if there isn't still much confusion about this issue.

It is conceptually simple to reject the "medical model" if you think that that simply means staying away from hospitals and psychiatrists. Some people do think that. It is more difficult, and much more important, to reject the "medical model" when it represents a concept of human "therapeusis" as a technical operation on a passive, mechanically organized receptor, guided by a normative antipathy for deviation. I call this medical model "deviance-alleviance"--and I think that it is quite prevalent amonst psychologists of all persuasions.

It is not unusual, for example, to find people, who may or may not be called community psychologists, who approach any or all societally defined "problems" as worthy of their intervention. And then the intervention tends to be a manipulation that denies the ability of people, individually or in groups, to define and manage their own situations. This strategy fails, of course. Failure is built in. The most it can offer is symptomatic alleviation. No cure. No ambrosia. Just a little psychological salve for your poverty, perhaps; a little palliative for the tensions of the street, the loneliness of the office, the hostilities of the family.

In a recent paper entitled "Medical Nemesis" Ivan Illich (1974) examines the price paid by society for its reliance on the deviance-alleviance interventions of modern medicine. He points out that more suffering is incurred through iatrogenic, or medically generated, diseases than through accidents in traffic or industry. Depression, infection, chronic disabilities and disfunctions all result from an increasing attitude of passive dependence upon technical intervention for the relief of suffering. Is modern medical practice at fault? No, not as a body of technical knowledge per se. But medicine is at fault to the extent that it blindly accepts and operates according to the pure ideology of deviance-alleviance. Then the patient

loses his autonomy and his suffering is not his own. The ultimate example is the modern denial of the personal experience of death: "let the doctor know when I am dead, I don't want to know."

In a sense, community psychology began with the discovery of iatrogenesis in the mental health delivery systems when large mental hospitals became recognized as breeding grounds for every form of madness. But for the most part, the response to this discovery was to eliminate the physical structures--removing the patient to the "community"--without eliminating the social structure, the deviance-alleviance ideology, which continues to make our mental health services generators of their own mental diseases.

And so, trying to be a community psychologist, I am working to find ways of understanding and eliminating iatrogenesis in a medical setting. This often means starting with basics--getting medical students to see that a patient's attitude makes a difference, or pointing out to nurses that a person's cultural background will influence his attitude toward medication. But the iatrogenic effects of medicine spill over into community mental health. And if the ideology of deviance-alleviance can be eliminated in the home of the medical model, perhaps there is a chance that new alternatives will develop in psychology.

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